WESLEY Medical Center

Scheduling: 962-7900
Fax To: (833)965-0104

Last Name:	First Name:	MI:
Birthdate:	SS #:	
Phone Number (Home):	(Work):	
Appointment Time:	Appointment Date:	Check in time in Admissions:

PHYSICIAN ORDER FOR NUCLEAR MEDICINE IMAGING

DIAGNOSIS/SYMPTOMS	CONTACT NUMBER FOR CRITICAL RESULT	FORM COMPLETED BY (PRINT NAME)
		☐ *Page when results are available* / Fax results to:

DATE/TIME	ORDERING PHYSICIAN'S NAME	ICD-9 Code	Order may be modified at the discretion of the Radiologist.
	PHYSICIAN'S SIGNATURE		☐ Please notify physician if order is modified.

NUCLEAR MEDICINE

Note: Please circle exam.

- ○ Thyroid uptake
- ○ Thyroid uptake/scan
- ○ Whole body bone scan
- ○ Limited area bone
- Diuretic Renal scan ○
- Lung scan ○
- ○ Hepatobiliary scan
- ○ Myocardial Perfusion
  - ○ Treadmill
  - ○ Pharmacological
- ○ RVG (MUGA)
  - ○ Stress
- ○ RVG (MUGA)
  - ○ Resting
  - ○ Before Chemo
  - ○ During Chemo
  - ○ After Chemo
- ○ Cisternogram
- ○ Sentinal node injection

Pertinent Medical History:

Patient's weight:

Other: